SIR,—Your discussion on "Medical care in the inner cities" (19 August, p 545) raises issues well beyond inner cities in this country. The issues relate to dilemmas, rather than to controversies, all over the world, as two recent events show. The WHO conference on primary health care at Alma-Ata, USSR, on 6-12 September, shows the uncertainties and hope placed on this level of care. A recent book, *Health Care in Big Cities*,[1] shows that New York, Sydney, Paris, Toronto, Bogota, Mexico City, Sao Paulo, Hong Kong, Manila, Tokyo, as well as London have inner city crises and that we may begin to learn from their efforts at resolving them.

Your controversy centred on general practice, and it is right that it should be so, since many problems relate to current changes and trends. A sign of a not-so-good trend is the fact that of the last 100 temporary residents whom I have treated no fewer than 35 did not know the name of their home general practitioner with whom they are registered. The problems of the inner cities are not theirs alone. They are those of general practice as a whole. They are those of falling standards and missing objectives at which to aim.

I believe that there are a number of "A's" which should be part and parcel of good general practice everywhere. It should provide personal care that is: available, accessible, acceptable, adaptable, affordable, attainable, assessible.

The present situation is such that unless we, as a profession, take action, correct faults, and improve standards, others will, much to our discomfiture. We have the structure, within the BMA and within the local medical committees and area (or district) medical committees. What seems to be lacking is the leadership and the sense of priorities to put faults right and to provide better care for our patients.

JOHN FRY

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[1] Paine, L H W (editor), *Health Care in Big Cities*. London, Croom Helm, 1978.

SIR,—The discussion article on "Medical care in the inner cities" (19 August, p 545) was timely. The problem resembles that of the cities in industrialising Britain during the last century—a population of migrants separated from their roots (social, medical, and educational factors) and the young socially aspiring doctor not interested in working in the locality. But the term "geographic disintegration" suggests a backsliding from an integration of care which never in fact existed.

The solution, a century ago, was to open the great teaching hospitals in these poor areas. This provided a much needed illness service and a pool of teaching and research material. It is now time for the medical schools to look at the health of their districts and not merely at their hospital beds. This act of imagination would bring service where it is needed and help counter the tendency, brought about by the revolution in the physical sciences, for sight to be lost of the patient as a whole person. It would supply material for teaching and research in psychological and social, as well as physical, terms. Dr Robert Smith and Professor Butterfield set up an integrated health care system at Thamesmead through Guy's Hospital Medical School, but this was in a new housing estate. Most medical schools, however, have installed a token lecturer in general practice (for example, the Middlesex Hospital, St Mary's Hospital, and St George's Hospital medical schools) who has left the care of patients off his list of priorities because of inadequate support. Each medical school, aided by the Department of Health, could set up a series of integrated medical centres, each caring for a geographical patch in the excitingly difficult localities in or near their district, and this would embrace the suggestions offered by Dr Michael Downham. I cannot speak for other conurbations, but in London it is possible for doctors to live not far from their practice, and in middle-class neighbourhoods if they wish.

Such are the levers of power and prestige that we cannot expect a systematic improvement in primary health care until the leaders of the medical schools will look outside at the community—its desperate need and exciting challenge.

RONALD LAW

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SIR,—As a young vocational trainee in an inner city practice who intends to work in inner London I read your discussion on medical care in the inner cities (19 August, p 545) with particular interest.

Dr Michael Downham's analysis of the problem is broadly correct: that it is a political and social problem. When the tower blocks are gone and the juggernaut lorries stop destroying the streets so that children can play safely and people have housing with defendable space situated on the ground then the medical, especially the psychiatric, work load will decrease. However, some of his solutions would put me off. (1) A salaried service and no independence would drive me out. (2) Integrate me with the social services and religious agencies—no, thanks. (3) Induce me to depend on the hospital consultants who also have chronic patients' problems—no, thank you.

What I suggest is: (1) Vocational training schemes like Guy's in which the best jobs are in the rotation. (2) Provision of housing and practice premises which a young general practitioner can buy if he wishes. (3) Ensuring of independent contractor status. (4) Considerable financial incentives (around £20 000 pa). This would induce the young doctors with whom I trained to think again about inner city practice, especially considering the other advantages: a wide range of hospitals and consultants to choose from, interesting and exciting medicine, real social problems, and warm friendly communities (if one bothers to look for them).

Finally, it is a sad reflection on the medical profession and the Government that if inner city practice was more profitable in Southwark than in Harley Street the standard of care would be the best in the world.

DAVID STEPHENS

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SIR,—In this week's edition of the *BMJ* (19 August, p 545) I found the discussion on "Medical care in the inner cities" most significantly important to the future of general practice and equally stimulating.

Having had my own (singlehanded) practice in Hampshire for 18 years, and with 20 years at sea as ship's surgeon (RFA), I find, on returning to general practice, that patients much prefer the singlehanded practice, where the doctor works from small premises (or possibly his own house), without an appointments system, and "without the trappings which the group practice acquires."

I found Dr G M Preston's remarks (p 548) very much to the point and stimulating.

F R CORFE

Bristol

Breakfast and Crohn's disease

SIR,—I am, of course, concerned that neither of the studies which you published (19 August, pp 539 and 540) confirmed my finding (9 April 1977, p 943) of an association between Crohn's disease and the pre-illness eating of breakfast cereals, particularly cornflakes. I have, however, reservations about both the recent papers.

When causation is being considered it is essential to ascertain the pre-illness and not the current habit. Drs L N J Archer and R F Harvey did not do this except in a subgroup of 14 recently diagnosed cases. Just how fallacious this could have been is suggested by their observation that two among this subgroup had stopped eating cornflakes regularly on diagnosis: they were included among the four regular eaters, so that, if current habit had been recorded in this subgroup, there would have been two regular eaters and 12 rare or non-eaters. The estimate from this tiny group is that half of the regular eaters abandoned the habit when they fell ill. In the remaining 43 cases of longer standing current habit only was recorded. How do the authors know that, among these, the same thing had not happened on the same scale? If it had, their figure for regular eaters among the patients would be an underestimate by the rather substantial factor of 100%. On this basis it can be calculated that a highly significant association would have been demonstrated.

I do not know how many of my patients had given up eating cereals, because I did not record current habit, but many had done so. The experiences of Martini and Brandes[1] and of Miller *et al*[2] in their striking study of sugar consumption were similar in respect of the foodstuffs with which they were concerned.

My other main reservation concerns the duration of symptoms and the effort of memory being required of the patients. The mean diagnosis/survey gap in the study reported by Drs Archer and Harvey was 11 years, but this does not signify, because they recorded current habit, with the consequences already noted. Drs P M Rawcliffe and S C Truelove simply say that in many of their patients the disease was of long standing. In my original study the mean onset/survey gap was 4·2 years and, for comparison, in the Marburg study[1] it was 4·5 years. It is the combined effect of a change of habit followed by a long delay before survey which is so liable to vitiate this kind of study: if a patient with long-standing Crohn's disease has not eaten cereals for a dozen years or more a period when he did do so may have become foreshortened beyond recall. This mechanism does not operate with the controls, in whom there is no systematic tendency to abandon or to take up the cereal habit which, in adults, is independent of age.[3] In this way the use of long-standing cases for retrospective survey may have led Drs Rawcliffe and Truelove into serious systematic error.

The difficulties of surveys of this kind are